KENTUCKY PANDEMIC INFLUENZA PREPAREDNESS PLAN
HEALTHCARE PLANNING SUPPLEMENT II

I. RATIONALE/OVERVIEW

All state and local governments, as well as healthcare facilities, are required to have an emergency response plan that addresses all hazards. However, pandemic influenza is likely to pose unique and long-standing challenges that may not be addressed in current emergency response plans. For example, in a pandemic emergency situation, it is expected that notification and response will be initiated at the national or international level, followed by state and, finally, local levels. Because of these unique challenges, the emergency response plans of hospitals, nursing homes, and other healthcare settings should incorporate a pandemic influenza plan as an appendix to their existing plans or have a separate pandemic influenza plan. It is also recommended that physician practices develop plans to manage the anticipated large numbers of patients seeking care. Considerations include: telephone triage, separate entrances, and segregated seating for patients with ILI (Influenza-Like Illnesses).

In addition, healthcare settings may prepare by developing lists of patients, using the CDC priority groups for vaccination as a guide. Lessons learned from Hurricanes Katrina and Rita demonstrate that special populations are at risk for accessing and utilizing emergency services both in the private and public sectors. Pre-pandemic planning efforts must be made to identify special populations, as well as mechanisms to ensure community delivery of resources exist or are considered.

Much of the healthcare planning necessary for a pandemic influenza response is being met through the cooperative planning efforts of the 14 statewide Kentucky Healthcare Planning Regions . Each region consists of health partners from hospitals, local health departments, EMS, mental health, long-term care facilities and other health-related stakeholders.

The purpose of this plan is to provide guidance to health systems in their response to pandemic influenza. Guidance is given during each phase of a pandemic and is broken down into specific sectors of the healthcare systems' response, including Healthcare Planning Regions, Community Mental Health Centers and other congregate facilities with special populations.

II. GUIDELINES FOR HEALTHCARE SYSTEMS RESPONSE (Interpandemic and Pandemic Alert Periods)

A. Healthcare System Response

The Healthcare System Response, utilizing the 14 regions throughout the state, in conjunction with other public and private sector stakeholders as appropriate, will:

1. Update and/or inventory state, regional and local medical supplies.

2. Collaborate with the appropriate agencies outside the healthcare system to inventory and identify statewide resources necessary for a pandemic influenza response.

3. Ensure that all partners in the healthcare system (i.e., hospitals, health departments, EMS, mental health centers, long-term care facilities and other health related stakeholders) have pandemic influenza plans and protocols in place.

4. Develop and coordinate recommendations on health issues related to pandemic influenza. Multiple stakeholders, including state agencies and regional/local health care systems, meet no less than quarterly to discuss pandemic influenza planning and other response issues through the HEALTHCARE regions, with most meeting on a monthly basis.

5. Review major elements of the health sector and essential non-health sector response plans.

6. Collaborate as needed with infectious disease and influenza experts to develop and revise recommendations on health-related issues.

7. Develop, based on the disease epidemiology, protective action recommendations specific to the disease to be implemented during the pandemic.

8. Estimate the impact of pandemic influenza on essential services.

9. Develop and maintain an inventory of available beds in healthcare facilities, including hospitals, nursing facilities and non-traditional settings that might serve to house sick patients as hospital overflow.

10. Alert local hospitals, health departments, EMS, long-term facilities, local health authorities, schools, community mental health centers, county emergency management coordinators and other community health partners to pandemic potential.

11. Meet at least quarterly to review the existing Pandemic Influenza Plan. The HEALTHCARE regions are responsible for assuring maintenance, updates and annual review of the plan. Healthcare members with responsibility for particular sections of the plan are responsible for coordinating the review of their sections.

12. With input from multiple stakeholders (including local and regional bioterrorism planning groups), the HEALTHCARE regions will ensure that pandemic influenza is included in planned scenarios for exercising and training purposes.

13. Conduct regular tabletop exercises to include partners outside the healthcare system as training for an all hazards/pandemic event according to Homeland Security Exercise and Evaluation Program (HSEEP) standards. Also, participate in other local/regional tabletop, functional or full functional exercises that include a pandemic scenario. An After Action Report (AAR) should be done for every exercise that reviews the strengths and weaknesses in the execution of the plan.

14. Update regional and local authorities, other public and private sector stakeholders, including special populations and the general public, with current information and non-pharmaceutical prevention strategies.

B. HEALTHCARE Regions

HEALTHCARE Regional Groups with assistance of appropriate healthcare stakeholders will:

1. Coordinate data collection, collect data from appropriate sources, and adjust for data duplication to maintain a regional inventory of:

a. Medical personnel, including but not limited to, currently licensed physicians, physician assistants, registered nurses, licensed practical nurses, medical assistants, and others who may be trained in the event of an emergency (those with previous patient care experience who currently work outside of patient care or retired healthcare personnel). This is done through the K HELPS System. See Appendix 3 of this Supplement.

b. Beds (hospital and long-term care)

c. ICU capacity

d. Ventilators

e. Pharmacies and pharmacists

f. Laboratories

g. PPE (e.g., masks, gloves)

h. Specimen collection and transport materials

i. Contingency medical facilities (within jurisdiction)

j. Mortuary and funeral services

k. Social services, disaster mental health services, and faith-based services

l. Sources of medical supplies (syringes, gloves)

m. Interpreter services

2. Analyze surge capacity in public and private sectors to determine potential needs.

3. Ensure private healthcare systems have pandemic influenza plans and protocols and provide assistance where deficiencies are found. Healthcare agencies should be planning for provision of care to include: hospital surveillance, education and training, triage,

clinical evaluation, admission procedures, facility access, occupational health, use and administration of vaccines and antiviral drugs, surge capacity, security, and mortuary issues.

4. Estimate the impact of pandemic influenza on healthcare services and special populations for providing and reinforcing preventive action recommendations to communities and determining pre-event health-related needs.

5. Identify locations of relative quiet/calm to be used for overflow patient care including those presenting with anxiety, psychosomatic or stress-related/induced symptoms, and strategies for the management of overflow locations (i.e., advance-planning protocols to triage overflow locations).

6. Request hospitals and community service providers, such as police and utilities, to develop and maintain contact lists of essential community services personnel (including work and home communication information) whose absence would pose a serious threat to public safety, critical infrastructure, or would significantly interfere with the ongoing response. The list should also include back-up and replacements personnel. Retired personnel may also be utilized.

C. Community Mental Health/Mental Retardation Centers

Community Mental Health/Mental Retardation Centers will:

1. Review internal emergency response plans and Disaster Mental Health Appendix to the Regional/Local Emergency Management Plan. Review shelter-in-place and evacuation procedures.

2. Update and/or inventory medical supplies.

3. Identify medical staff including back-up personnel with special emphasis on non-traditional volunteers. Identify and maintain lists of essential medical and service staff (including work and home contact information) whose absence would significantly interfere with the response and/or patient care.

4. Estimate the impact of pandemic influenza on service provision.

D. Congregate facilities serving special needs populations should follow the same recommendations as section C above.

III. GUIDELINES FOR HEALTHCARE SYSTEMS RESPONSE (Pandemic Period)

A. International identification

1. HEALTHCARE Regional Groups with assistance of appropriate healthcare stakeholder will:

a. Encourage hospitals and congregate facilities to review and update pandemic influenza plans.

b. Collaborate with regional and local emergency management coordinators to maintain a high level of awareness and preparedness among emergency responders and healthcare providers to include mental health.

c. Coordinate notification of appropriate agencies, infection control practitioners, local laboratories, emergency rooms, community health providers, and community health workers within their own jurisdictions.

d. With federal and state guidance, provide public and private healthcare providers with updated case definitions, protocols, and algorithms to assist with case finding, management, infection control, and surveillance reporting.

B. National/Kentucky Identification

1. HEALTHCARE Regional Groups with assistance of appropriate healthcare stakeholders will:

a. Activate emergency/pandemic influenza response plans

b. Collaborate with regional and local emergency management coordinators to maintain a high level of awareness and preparedness among emergency responders and healthcare providers to include mental health.

c. Coordinate notification of appropriate agencies, infection control practitioners, local laboratories, and emergency rooms within their own jurisdictions.

d. With federal and state guidance, provide public and private healthcare providers with updated case definitions, protocols, and algorithms to assist with case finding, management, infection control, and surveillance reporting.

IV. GUIDELINES FOR HEALTHCARE SYSTEM RESPONSE (Postpandemic Period)

A. International Circulation

1. HEALTHCARE Regional Groups with assistance of appropriate healthcare stakeholders will:

a. Continue to collaborate with regional and local emergency management coordinators to maintain a high level of awareness and preparedness among emergency responders and healthcare providers to include mental health.

B. National/Kentucky Circulation

1. HEALTHCARE Regional Groups with assistance of appropriate healthcare stakeholders will:

    a. Notify involved agencies of change of status to the Postpandemic Period.

2. Mental Health will:

    a. Coordinate the assessment of the impact on mental health facilities.

    b. It is expected that the psychosocial and financial effects of a pandemic will be felt for months if not years, hampering personal, community and agency recovery. It is the expectation that crisis counseling program services will be available for a period of at least one-year post declaration date.

Appendix 1: Planning Guidance Update July 2008

- *Form community-wide coalitions to include hospitals, urgent care facilities, other ambulatory care facilities, public health, long term care facilities, nursing homes, home health care agencies, community health centers, primary care offices, mental health and substance abuse treatment facilities, EMS, and other first responders to accommodate surge in patients expected from pandemic influenza.*

Since the inception of the Hospital Preparedness Program, the Commonwealth has been divided into regional health and medical emergency planning committees (known in Kentucky as Healthcare Planning Coalitions) to plan for response to health and medical events. Partnerships have grown and evolved over the last few years since 2002. To date, coalitions include: hospitals, public health, long term care facilities, nursing homes, home health providers, community health centers, primary care, mental health, EMS, and other first responders. Other stakeholders mentioned above can be invited at any time to participate in the coalition planning efforts.

- *Assist healthcare facilities in conducting exercises and drills to test health care response issues and build partnerships among health care and public health officials, community leaders, and emergency response workers.*

Through Hospital Preparedness funding, healthcare planning coalitions receive funding each year to conduct community exercises with health and medical response partners. A specific pandemic influenza exercise is currently being planned for each HPC during the FY 2008 funding cycle.

- *Address the medical concerns and needs of at-risk individuals and populations*

There are many facets to Kentucky's approach to vulnerable populations. The Kentucky Outreach and Information Network (KOIN) is a communication tool developed by KDPH to break communication barriers with at-risk individuals. This tool can be utilized to communicate with hard to reach populations. In addition to the KOIN, KDPH and KHA have invested in pictograms to assist in impromptu communications at the healthcare setting.

KDPH is in process of developing special medical needs shelter (SpNS) capacity. KDPH, along with local health departments, are currently identifying roles necessary to staff a special medical needs shelter. In addition, local communities are also using preparedness funding to purchase equipment for use in a SpNS. Kentucky is currently struggling with identifying numbers of individuals that might have special needs during an event. A special needs registry pilot project is currently underway. If successful, this project will continue statewide.

Assist non-hospital community-based providers for at-risk individuals (e.g. day psychosocial treatment centers, advocacy organizations with recreational programs, and facilities managing congregate living in the local community) in participating in exercises and drills to test at-risk response issues and build partnerships among providers and public health officials, community leaders, and emergency response workers.

Limited mental health participation has occurred within the state. An exercise is planned for July, 2008 to exercise ESF-8 and the NDMS program. Special needs individuals will be used as patients during this exercise.

- *Develop an interoperable communications infrastructure to facilitate and ensure the timely dissemination and transfer of information between health care and other sectors (such as emergency management, public safety, EMS, service providers for at-risk individuals, etc.).*

Through Hospital Preparedness funding, Kentucky has invested heavily in a satellite radio/phone that links all hospitals, health departments, and regional emergency management agencies together. Additionally, select local EMS providers and local Emergency Management agencies are on the network.

While services providers are not directly connected into the satellite radio/phone program, KDPH does have the ability to communicate to these service providers through the Kentucky Outreach and Information Network (KOIN).

- *Address legal and ethical issues that can affect staffing and patient care (such as credentialing issues and providing care with scarce medical resources).*

Work is being done through the K HELPS program to increase surge capacity issues. Some legal issues have been addressed and clarified. For example, through a partnership with Kentucky Emergency Management, workers compensation benefits can now be extended to K HELPS volunteers. Additionally, professional liability coverage is addressed through the insurance policy for some volunteers such as nurses, paramedics and EMTs.

Legal and ethical issues for patient care regarding antivirals are outlined in the Community Containment Supplement. Kentucky has adopted the federal guidelines on priority groups for antiviral and vaccine distribution.

- *Assist the health care community with planning for provision of care in hospitals to include: hospital surveillance, education and training, triage, clinical evaluation, admission procedures, facility access, occupational health, use and administration of vaccines and antiviral drugs, surge capacity, security, and mortuary issues.*

KDPH has partnered with the University of Louisville to provide training, education and planning assistance to every Healthcare Planning Region in Kentucky on evacuation and natural

death surge issues. The work will result in tabletop exercises done in every region in the state to address these issues. In the Healthcare Planning Supplement, recommendations to healthcare agencies include these areas. A regional pandemic influenza tabletop exercise is being made available to regional planning coalitions.

- *Assist the health care community with planning for provision of care in non-hospital settings to include non-hospital health care facilities (e.g. long term care facilities, dialysis centers, nursing homes, mental health and substance abuse treatment facilities, Federally Qualified Health Centers (FQHCs), etc.), home healthcare networks and/or alternative care sites.*

Long term care facilities and nursing homes are becoming integrated into the healthcare planning structure. Participating facilities are planning for providing healthcare in alternative care locations. In addition, FQHCs and home healthcare providers are members of the HPCs and participate in community planning efforts.

During the FY 2007 HPP grant cycle, hospitals are developing alternate care site location plans and beginning to develop operational plans (per Joint Commission requirement).

KDPH is in process of developing special medical needs shelter (SpNS) capacity. KDPH, along with local health departments, are currently identifying roles necessary to staff a special medical needs shelter. In addition, local communities are also using preparedness funding to purchase equipment for use in a SpNS.

- *Anticipate needs for medical supplies and equipment to treat complications of pandemic influenza and determine how supplies will be maintained.*

Beginning with the FY 2002 HPP grant cycle, and influenced by the HEALTHCARE program emphasis on isolation and quarantine, many hospitals acquired HEPA-based PAPRs and have subsequently developed either additional isolation/quarantine, or temporary isolation/quarantine using portable negative air systems.

Kentucky Department for Public Health (KDPH) and Kentucky Hospital Association (KHA) have partnered to develop several regional stockpiles of biological PPE items. In regionally located warehouses significant quantities of tie-on surgical masks (adult and pediatric style) have been stockpiled. In a secure central warehouse folding N-95 masks (>900,000), liquid hand sanitizer (>70,000), tie-on surgical masks (>12,000,000), and PAPR systems (>180) are currently in storage.

While healthcare facilities and HPC regions have developed limited caches of biological PPE, these are likely to be inadequate to meet the demand during a pandemic. There is, therefore, a need to consider increasing PPE stockpiles with the following items:

- Fluid-resistant gowns (Tyvek or equivalent)
- Nitrile gloves (selected to be less tear-prone; likely to last longer in storage than latex)
- Eye protection (face shields, glasses, etc.).

There is also a need, as an on-going expense, to extend the lease for the central warehouse storage space for the state stockpiled pandemic supplies that have been acquired through previous HPP grant cycles.

In addition to the PPE currently in storage, Kentucky participated in the HHS antiviral subsidy contract. Through this contract the state has purchased 194,592 treatment courses of Tamiflu and 21,632 treatment courses of Relenza. Kentucky entered into a partnership/contract with the Kentucky Pharmacist Association (KPhA) for the long-term secure and environmentally appropriate storage of the states stockpile of antiviral medications.

Additional considerations for the Department of Veterans Affairs (VA) and the Indian Health Service (IHS)

- *Are VA and IHS beneficiaries included in the State numbers for PPE, antiviral drugs, vaccine, etc.?*

Kentucky does not have Indian Health Service.
In Kentucky, there are two VA Hospitals in Lexington and Louisville and four nursing homes. The hospitals are actively engaged in the regional planning coalitions. The VA does maintain a small stockpile of PPE and other disaster related materials. Kentucky's veterans are included in the count of the general population (approximately 10% of Kentucky's population) when planning for mass dispensing. (See VA Appendix in Supplement 10: Other Governmental Agencies)

- *Have States encouraged local planners to establish a communication network with local VA and IHS facilities?*

Yes, VAs are an important component to our healthcare planning coalitions. The VA hospitals in Lexington and Louisville are both actively engaged in the regional planning coalitions.

- *Have State planners included State and federal VA partners in their planning process? Yes, the VA is written into ESF-8 operations through use of the NDMS program. Further inclusion should be considered.*

- *Do State planners understand the VA and IHS roles in the National Response Framework?*

(See VA Appendix in Supplement 10: Other Governmental Agencies)

- *Do State planners understand the process for requesting VA and IHS assistance?*

Below is the contact information for the VA Area Emergency Manager.

A summary of the ways in which the VA is included in the National Response Framework can be found VA Appendix in Supplement 10: Other Governmental Agencies.

Gerald Cartier
110 Veteran's Drive
Lexington, KY 40502
(859) 281-3811
Cell: (859) 333-3814

Appendix 2: National Hospital Available Beds for Emergencies and Disasters (HAvBED) System (HAvBED) System in Kentucky

Kentucky utilizes EMResource program from EMSystem to manage hospital beds status tracking, interfacility messaging, diversion management, and document sharing since FY 2003. The program started in the Louisville metropolitan area as an activity of the Jefferson County Medical Society's EMS Committee, and was then taken statewide as a management system for all regions.

When the HAvBED requirement was added to the HPP program in 2006, EMSystem was one of the pilot systems used in the national demonstration projects. During the period of time between Hurricanes Katrina and Rita, EMSystem was used to gather national information for HHS on the status of hospitals, and this information was then shared nationally.

EMSystem is configured and prepared to gather and transmit HAvBED information to ASPR once the final interface standards are released. During the past four months Kentucky has been conducting regular training and HAvBED tests with its user base to gain familiarity with the HAvBED process. The results are steadily improving, and we should be in a good position to transmit HAvBED data when ASPR is ready to receive.

Appendix 3: Kentucky Health Emergency Listing of Professionals for Surge (K HELPS)

Kentucky will have a functional ESAR-VHP to meet the requirements set forth in the Interim Technical and Policy Guidelines, Standards, and Definitions by August 8, 2008. Kentucky has made great strides in the development of an ESAR-VHP over the previous two years. To date, Kentucky has developed an ESAR-VHP Advisory Committee, renamed ESAR-VHP to Kentucky Health Emergency Listing of Professionals for Surge (K HELPS), purchased the Global Secure Volunteer Mobilizer, completed system design, and established Level III credentialing for a number of healthcare professions. Kentucky is a Phase III ESAR-VHP state therefore no exercises have yet been conducted. However, a statewide exercise is planned for July 2008. It will alert volunteers and test some of the information taught in the Orientation course on volunteer activation.

Unique partnerships have been formed with the Medical Reserve Corps (MRC) program to allow local MRC Unit Leaders access to the K HELPS volunteers in their jurisdiction in order to complete the credentialing, training, administration of ID badges and final approval for volunteers. In addition, Kentucky Community Crisis Response Board also has access for credentialing, training, and administration of ID badges for mental health professionals. ID badges have been developed to meet FIPS 201 guidelines.

ESAR VHP Program Manager has met with HPP Regional Leadership to discuss utilization of volunteers in hospitals for surge capability. Local MRC Coordinators (K HELPS local leads) have been encouraged to work closely with their Healthcare Planning Coalition and local hospitals so regions may utilize both K HELPS and MRC as a resource for surge capacity. A partnership with the VA Hospital has also been established. The online registry now contains a question to determine if the volunteer is a current, past, or retired employee of the VA Hospital. VA would like to develop teams of these individuals due to their specialized training.

A training matrix has been developed to include the minimal amount of training necessary to approve a volunteer. The training plan is based on the National Competency Matrix developed by the Medical Reserve Corps Program Office. Five (5) training courses are complete to date and available on line via the Kentucky TRAIN system. Completion of IS 700 National Incident Management System (NIMS) and an orientation course are both mandatory in order to meet NIMS compliance. Continuing education credit for the trainings has been established both for online trainings and trainings offered face to face with volunteers by local MRC Unit Leaders.

A marketing plan was done in 2007 to include: a letter mailed from the Commissioner of Public Health to all physicians and nurses in the state encouraging their participation; a radio public service announcement (PSA) campaign that ran two (2) weeks in September 2007 and had the potential to reach 75% of adults in most areas of the state; promotional items including magnets and lanyards for volunteers; brochures, flyers, posters; the creation of a logo specifically for K HELPS; and a display board for use at the State Fair. The 2008 marketing plan includes additional direct mails to other professions required by ESAR-VHP as well as the development of local and regional marketing tools.

Legislative and administrative issues were initially addressed in 2007. Kentucky House Bill 287 became law in early 2007. This bill gives legitimacy to the program and makes the CHFS responsible for health volunteers in the state. A partnership has been formed with Kentucky Emergency Management to provide Workers Compensation benefits to volunteers

registered in K HELPS. However, professional liability coverage continues to be a problem for the state.

Kentucky has developed a MRC Unit Leader Guide that explains many components of how MRC and K HELPS work together. Additionally, a template for local MRC Unit Leaders to develop a volunteer handbook has been established and was presented to Unit Leaders in December 2007. One of the MRC Units in the state has offered to help develop a K HELPS/MRC annex to the local EOP.

Future initiatives are underway at this time. A goal of 2,000 registered volunteers was set and was reached long before the August 2008 date projected. The K HELPS administrator is exploring the viability of hosting the state's special needs registry on the Volunteer Mobilizer system, thus further integrating ESAR-VHP, MRC, and the special needs community. Additionally, the system might be used by CERT programs in the future for database management.

Appendix 4: Non Hospital/Alternate Care Site

During FY 2008 each of the 14 HPP Regional Planning Coalitions will be tasked with evaluating and identifying potential facilities for special needs shelters. It is acknowledged that the special needs shelter may be co-located with an American Red Cross Shelter or a general shelter run by another organization. These facilities will be listed in the Regional HPP Plan and in the Emergency Resource Inventory Listing (ERIL) of the county emergency operations plan.

During FY 2007, KDPH in partnership with HPC Region 3 developed the following ACS planning tools for rural areas:

- Site Selection Matrix
- Staffing Algorithm
- Equipment Listing
- Just in Time and Preplanned Trainings for volunteers
- Medical Surge Tabletop Exercise

Many planning needs still exist in the Alternate Care Site sub-capability. An Alternate Care Site Selection matrix should be distributed to each of the 14 HPC regions. Each region, based upon the matrix, needs to identify ACS facilities for hospitals and other healthcare facilities. Each of the identified sites need to be cross referenced to ensure no overlap in planning assumption and each list needs to be incorporated into the local emergency management Emergency Operations Plan (EOP). In addition, KDPH should develop guidance for the Federal Medical Stations that the Strategic National Stockpile holds for deployment. Each region needs to identify possible locations for reception of the FMS.